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February 6, 2008

MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: William W. Lawrence, Jr., MD

Mike Moseley

SUBJECT: Implementation Update #39: CAP - MR/DD Waiver Update, CAP-MR/DD Technical Amendment #4 Update, Endorsement, Accreditation Update, Community Support Comprehensive Service Provider, Maintenance of Service, Gaps in Service Authorization, Person Centered Plan Updates/Revisions, Four Requirements for Removal from Payment Withhold

CAP-MR/DD Waiver Development Update

The development of the tiered waivers continues with staff from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS), the Division of Medical Assistance (DMA) and external stakeholders. A two day meeting of an external stakeholder workgroup occurred on January 31, 2008 and February 1, 2008. The workgroup participated in the review of the specific components of the draft tiered waivers. Future external stakeholder meetings will be scheduled, followed by public forums across the state, where information will be provided and input will be solicited regarding the tiered waivers and the development of new and current service definitions. Information will also be posted on the DMH/DD/SAS and DMA websites for public review and comment. Specific dates and locations will be announced as scheduled. The following is a brief summary of the ***proposed framework*** for the tiered waivers:

- Tier #1:
  - For individuals who live on their own or with their family and who have low intensity support needs and/or have access to unpaid supports that can meet a substantial portion of their overall needs
  - Will support individuals whose needs can be met within the range of $0 to $25,000
  - Will include a tier specific service array designed to meet the needs of this population
  - Allows for self-direction of services for consumers living on their own or with their family.
- Tier #2:
  - For individuals who live in their own home, with their family, or in a congregate residential setting in the community
  - Will support individuals whose needs can be met within the range of $25,001 to $60,000

    - Will include the current service array with some revisions
    - Allows for self-direction of services for consumers living on their own or with their family.
- Tier #3:
    - For individuals who live in their own home, with their family or in a congregate residential setting in the community
    - Will support individuals whose needs can be met within the range of $60,001 to $91,000
    - Includes the current service array with revisions to include enhancement of services to meet the higher intensity of service needs
    - Self-direction is not an option in this waiver
- Tier #4:
    - For individuals who experience severe medical fragility, and/or severe behavioral challenges
    - Will support individuals whose needs can be met within the range of $91,001 to $135,000
    - Includes a specific service array designed to meet the medical and/or behavioral needs of this population
    - Self-direction is not an option in this waiver

In an effort to provide a method for stakeholders to provide thoughts, ideas and comments concerning the development of the tiered waivers, a special e-mail account has been created. Please send any information you would like to this email account. The Division of MH/DD/SAS will NOT be providing direct responses to messages sent to this email account, but will use the information in combination with other activities to create the new tiered waivers. The email account is Tiered.Waivers.Development@ncmail.net.

CAP-MR/DD Technical Amendment #4 Update

The following information is intended to clarify questions specific to Technical Amendment #4 as indicated in Implementation Update #35, with regard to family members and legal guardians receiving payment for providing waiver services.

- Biological family members such as, cousins, grandparents, siblings, to adult and child family members receiving waiver services may provide a maximum of 217 hours of waiver services per calendar month as specified in the individual's Plan of Care.
- If the cousin, grandparent, sibling or other biological family member is living outside the home of the waiver participant they may provide up to 217 hours of services per calendar month in combination with other biological relatives living outside the home. If more than one biological relative is residing in the home with the waiver participant, then all biological relatives in the home may only provide up to 217 hours of waiver services to the waiver participant.
- Parents of minors may not provide paid waiver services to their minor child.
- The 217 hour limitation does not apply to step parents and/or aunts, uncles, step siblings, not biologically related to the waiver participant.
- If the biological relative is the legal guardian, the recommendation for providing paid services must be supported by the LME through a letter of recommendation.
- Each LME may decide to provide the letter of recommendation to the legal guardian when submitting this information to the Case Manager, or the LME may provide a copy of the letter of recommendation to the legal guardian if requested.
- Letters of recommendation may only be shared with other individuals as specified by a written release of information signed by the legal guardian.

Letters of recommendation regarding guardians as paid caregivers are to be submitted to ValueOptions at the next Revision/Plan of Care Update or at the Continued Need Review (CNR), whichever comes first. ValueOptions will consider the entirety of the Plan of Care Update/Revision or CNR, inclusive of the letter of recommendation, when reviewing for medical necessity of services.

REMINDER: The completion of the required processes to meet the requirements of Technical Amendment #4 is critical to ensuring compliance with the CMS approved Technical Amendment. This process MUST be completed for all waiver participants by February 22, 2008.

Endorsement

During the 2006 legislative session, the General Assembly enacted legislation which specified the roles and responsibilities of LMEs in G. S. 122C-115.4. One of the responsibilities of the LME listed in this statute is provider endorsement. The Attorney General's (AG's) office has communicated to the Department of Health and Human Services (DHHS) their interpretation of this statutory change to mean that DHHS is not involved in endorsement decisions; those decisions are under the authority of the LME. Consequently, appeals of endorsement decisions should not be heard by DHHS or the Office of Administrative Hearings. DHHS will continue to work with the AG's Office, LMEs and providers to clarify roles and responsibilities for each agency. Additional communication will be forth coming concerning this decision.

National Accreditation Update

In the January Implementation Update (#38), we offered a preliminary status report of the requirement for national accreditation for those nineteen (19) services which went into effect in March 2006, and for which the service definition includes the requirement that, "within three years of enrollment as a provider, the organization must have achieved national accreditation."

The services which require national accreditation include:

1. Community Support – Adults
2. Community Support – Children/Adolescents
3. Mobile Crisis Management
4. Diagnostic/Assessment
5. Intensive In-Home Services
6. Multisystemic Therapy
7. Community Support Team
8. Assertive Community Treatment Team
9. Psychosocial Rehabilitation
10. Child and Adolescent Day Treatment
11. Substance Abuse Intensive Outpatient Program
12. Substance Abuse Comprehensive Outpatient Treatment Program
13. Substance Abuse Non-Medical Community Residential Treatment
14. Substance Abuse Medically Monitored Community Residential Treatment
15. Substance Abuse Halfway House
16. Ambulatory Detoxification
17. Social Setting Detoxification
18. Non-Hospital Medical Detoxification
19. Medically Supervised or ADATC Detoxification/Crisis Stabilization

Currently, services provided under the CAP-MR/DD waiver do not have the national accreditation requirement attached to the service definitions. Neither are providers of child/adolescent residential Level II-IV services required to achieve national accreditation for the provision of these services. Only the services listed above require national accreditation at this time.

Since the January Implementation Update was published, we have received information from each of the national accrediting agencies who are approved by DHHS to accredit providers. We have compared their responses to the lists of currently enrolled providers for these services. Based on data obtained from the Medicaid enrollment database and IPRS, there are currently 998 corporate provider agencies of community intervention services requiring national accreditation. These corporate provider agencies include 2215 (site and service-specific) billing providers. Approximately four percent (3.9%) of the corporate provider agencies have attained national accreditation; an additional 4.5% are in the process of attaining accreditation, and 91.6% have not begun the national accreditation process.

We posed several questions to the accreditation agencies, two of which were:

1. For North Carolina, if NC is not different from other states, from the time the application is received, what is the average time (in months/days) it is taking for accreditation to be achieved by providers?
2. Could you offer a suggestion of a date, beyond which if you received an application for accreditation, you could be reasonably sure you could *not* complete the process by March 2009? In other words, what is the date beyond which you could not assure a provider that accreditation could be completed by March 2009?

Here is a chart with the responses of the agencies to these questions:

Accrediting Agency	Time Required before On-Site Survey	Estimated Latest Date by which Application Could Be Received for 3/20/09 Accreditation
CARF	6 months	July 31, 2008
COA	12-14 months	March 1, 2008
CQL	Request 6 months	September 1, 2008
Joint Commission	60-90 days	September 1, 2008

Given these dates established for us by the accreditation agencies and the comparatively small number of providers who have established formal relationships with the accreditation agencies, it is appropriate for the State and the LMEs to ask endorsed and enrolled providers of services requiring national accreditation to select an accreditation agency and show evidence of that selection. Acceptable evidence should be correspondence from the accreditation agency to the effect that the provider has become a client of the agency. Providers should keep in mind that the national accreditation agencies have

different methods, processes and perspectives. The selection of an agency with whom to partner in achieving national accreditation should be made after reviewing practices, standards and business methods of the accrediting agency to determine what that agency measures matches with the provider agency's practices, standards and business methods.

Over the next two months, DMH/DD/SAS and DMA, with consultation from stakeholders, will establish reasonable measures and timeframes by which to monitor the compliance of the provider community with this important requirement. Anticipating that the closer the time for the requirement to be fulfilled (March 2009 for most providers) the more intensely the progress of provider agencies will be reviewed. As that time approaches, if it becomes apparent through monitoring providers against this requirement, that the likelihood of a provider achieving accreditation by the time established is diminished, LMEs will be required to develop plans to transition consumers served by these providers to other providers in order to ensure continuity of service and minimize disruption in the lives of persons being served.

It is important to note that this is not a negotiable requirement. The three year time frame is identified in the State Plan Amendment (SPA) which serves as the source document for these service definitions, and is therefore a requirement of the Centers for Medicare and Medicaid Services (CMS) and not one within the discretion of North Carolina to modify. Questions have been directed to us asking what happens should a provider change ownership, or have had enrollment interrupted and reinstated over the course of this three-year period. In all of these cases, the earliest date of enrollment will be the one which is considered the effective date of the enrollment, and neither interruptions nor transfer of ownership would have the effect of restarting the calendar.

We offer this guidance in hopes that all providers of these services who have not done so will give immediate and serious consideration to the selection of an accrediting agency and beginning the process of achieving national accreditation.

The names of contact persons with the four accreditation agencies may be found in Communication Bulletin #50, ("Approved List of Agencies That (a) May Accredit Providers of MH/DD/SA Services, and (b) May Accredit LMEs for Systems Management"), Attachment A: "Contact Persons for Agencies Approved by DMH/DD/SAS and DMA to Accredit Providers of MH/DD/SA Services." That Communication Bulletin maybe found here: http://www.ncdhhs.gov/mhddsas/announce/commbulletins/commbulletin050accreditation.pdf

If you have further questions concerning this issue, please contact Jim Jarrard at Jim.Jarrard@ncmail.net.

Community Support Comprehensive Service Provider

The memorandum issued by the Secretary on November 8, 2007 suspended new enrollment of Community Support Services, and set forth a Community Support Plan that identified steps to be taken to assure that recipients of Community Support Services would receive quality services. One of those steps was the development of qualifications for a Comprehensive Service Provider. ***A Comprehensive Service Provider is defined as a provider agency that has a management infrastructure with the ability to support fiscal soundness, regulatory reporting, and quality monitoring and improvement practices that ensure the capacity for quality service delivery and coordination***.

Five operational categories have been identified to be indicators of a stable comprehensive provider agency. The operational functions are:

- Governance
- Fiscal Management
- Training
- Quality Assurance/Improvement
- Service Provision

The elements of each function area are attached in ***Appendix A, Community Support Comprehensive Service Provider Corporate Endorsement Standards. (http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm)***
This document should be used as a self assessment for any agency providing
Community Support Services.

The qualifications established for the Comprehensive Service Provider (CSP) can also be viewed as a transition to move the provider system toward standards that will be required to obtain national accreditation. As such, some of the elements will be waived for those agencies that have already achieved national accreditation.

There will be a period for public comment prior to the finalization of standards for a CSP. Comments will be accepted until March 1, 2008 and can be sent to Dick Oliver at Dick.Oliver@ncmail.net. Information related to the actual timeline for implementation will be forthcoming. DHHS will also develop a manual prior to implementation of this requirement that will detail how compliance with these standards will be judged.

Maintenance of Service (MOS)

Maintenance of Service is an authorization that allows a consumer to continue to receive services if the consumer has received a denial or reduction of services, but has appealed that reduction or denial. The process for appealing the denial or reduction and when MOS is applied is explained below.

If a service has been reduced or denied the consumer or legally responsible person has the right to appeal the decision by ValueOptions (VO). The provider can assist the consumer with making this request. Once a request for appeal is received by the Hearing Office, VO is notified. If the appeal is for a concurrent request, VO will enter the MOS authorization. MOS will be entered to reflect either the amount of units that were authorized prior to the denial or reduction or the units requested, whichever is less. Providers will be paid for services during the appeal process as long as all other Medicaid and DMH/DD/SAS requirements are met.

If an initial request for service authorization is reduced versus authorized as requested, this decision is entered, a letter and appeal rights is mailed to the consumer and provider. The consumer has the right to appeal this decision. However, since it is an initial request for service authorization, MOS does not apply and the consumer will only receive the units authorized by VO for the time period authorized by VO.

A consumer has the right to transfer to a new provider at any time. This is true even while an appeal is pending. If the consumer makes this choice and an appeal has been requested with MOS in place, the MOS will follow the consumer. The new provider should notify ValueOptions that they are now the provider and need the MOS authorization. An important point to remember: If no appeal was requested prior to the transfer, MOS will not apply as these requests will be treated as initial requests.

Gaps in Service Authorization

There have been questions relating to why gaps in service authorization arise when a concurrent service request is submitted for authorization. There are two instances when a request for service authorization is considered an initial request instead of a concurrent request; which result in a gap in the service authorization. They are as follows:

1. If a consumer transfers to a new provider for the same service, the authorization of the prior provider **does not automatically** transfer to the new provider. The requests from the new provider will **always** be treated as an initial request. Therefore, the provider takes a risk of non-payment by providing services prior to a new authorization from ValueOptions. In these cases, if the request from the new provider is denied or reduced, the consumer has appeal rights but Maintenance of Service does not apply to this initial request.
2. If a provider allows a lapse in authorization, the next request will be treated as an initial request. This means if a request is sent after the previous authorization has expired, even for the same service, ValueOptions, at the direction of DMA, will treat these as initial requests and not concurrent. There will be a lapse in payment for the provider because ValueOptions starts an authorization from the day it is received. In addition, a denial or reduction will mean no Maintenance of Service. However, the consumer will still have appeal rights.

Person Centered Plans Updates/Revisions

There have been many questions about the Person Centered Plan (PCP) and the requirement of an update/revision page to be submitted for all concurrent requests. The following information is provided to clarify this requirement:

- DMA and the Division of MH/DD/SA require an update/revision page be completed and signed by the Qualified Professional and consumer or legally responsible person with each submission to ValueOptions for all concurrent requests.
    - If the review results in a NEW SERVICE being added to the PCP, the appropriate medical professional must also sign indicating medical necessity and order of the service.
    - If the review results in a NEW or REVISED GOAL, complete the Action Plan Section of the Update/Revision Form with the new goal information.
    - If the review results in no changes to the PCP, document the review on the original Action Plan pages while obtaining new signatures on the Update/Revision Form. It is best practice to note somewhere on the Update/Revision Form that documentation of the review can be found on the original Action Plan pages with dates coinciding with the signatures on the Update/Revision Form.
- The Qualified Professional (QP) from the clinical home is responsible for the development of and updates for the PCP.
- If a child is in residential service or any service other than a clinical home, the QP of the clinical home **must** complete the update/revision page with signatures for the provider to submit a concurrent request to VO. This request for residential services should still be sent to the residential fax number at 919-461-0679.
- Residential providers and other non-clinical home providers can **not** complete these.
- The absence of the update/revision page will cause VO to return the request noting the information is missing. The QP has 15 calendar days to submit the documentation requested to VO. If 15 calendar days pass from the date the request was returned and the documents have not been submitted the request will be denied.

- After the 15 calendar days from the request for additional information, when a new request is submitted it is treated as an initial request due to the gap in authorizations, even for the same service. This means if there is a denial or reduction, appeal rights will be available to the consumer, however, MOS does not apply.

Community Support Service Providers – Four Requirements for Removal from Payment Withholds

Implementation Memo #38 noted in "Removal from Payment Withhold" the requirements which must be met by providers to be taken off of withhold status. The following guidance responds to questions received from providers.

I. Full refund to Medicaid of identified overpayments as a result of post payment review.

1. Payments to Medicaid
   - Providers received letters from Program Integrity dated December 21, 2007, identifying the amount of repayment due Medicaid as the result of Clinical Post Payment Review findings. Providers had 30 days to repay this amount in full, to avoid additional penalty and interest charges.
   - Providers who have not appealed to the DHHS Hearings Office and who have not repaid Medicaid in full are placed on 100% recoupment of their claims until the receivable has been satisfied.
   - If a provider agrees in writing to the amount of repayment owed, and is not able to make a lump sum repayment, they should contact DMA's Budget Office at (919) 855-4140 and request a six month recoupment plan. Interest (and a 10% penalty if applicable) will accrue on amounts owed during the six month recoupment plan.
2. Appeals
   - Providers may appeal the case findings cited in the December 21, 2007 Program Integrity letter, through the DHHS Hearings Office and/or the Office of Administrative Hearings.
     - To appeal to the Hearings Office, providers must have, within 15 days of receipt of the Program Integrity letter, sent the "Request for Reconsideration" form to the Hearings Office.
     - Providers have 60 days from receipt of the Program Integrity letter to appeal to the Office of Administrative Hearings.
   - For those providers who appealed to the DHHS Hearings Office, Program Integrity notified the Controller's Office of the appeal by sending the Controller's Office a copy of the DHHS Hearings Office Dispute Notice.
     - If the Controller's Office received a DHHS Hearings Office Dispute Notice, the provider has not been placed on 100% recoupment of monies owed, pending the DHHS Hearings Office's finding.
     - This recoupment deferral does not apply in cases where the provider has appealed to the Office of Administrative Hearings. In this situation 100% recoupment will take effect 30 days from the date of the Program Integrity letter.
   - At the completion of a DHHS Hearings Office appeal, the provider receives a Decision Letter from the Hearings Office. This letter will indicate the amount the Hearings Office has determined is due to Medicaid.
     - Based on the amount due to the Medicaid program, (as determined by the appeal at the DHHS Hearings Office) the DHHS Controller's Office will calculate a one-time penalty (10%) plus interest charges that have accrued from 30 days after the original date the amount was due to the Medicaid program (30 days from receipt of the Program Integrity letter).
     - The Provider is expected to make immediate payment to the Controller's Office upon receipt of the Hearings Office Decision letter.

II. Produce an LME-approved Plan of Correction

Providers are instructed to submit copies of their LME Plan of Correction Acceptance letters to:

ATTENTION: PARS/POC
DMA Program Integrity
One Bank of America
421 Fayetteville Street
Raleigh, NC 27606

III. Perform a self-audit of Community Support Services

Providers are to perform a self audit in accordance with the DMA Program Integrity self audit protocols, and repay the Medicaid program for any Community Support Services the provider determines were non-compliant with Medicaid requirements. **These protocols are located on the DMH website. Providers should go to the DMH website http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm and retrieve all documents, including the Affirmation Statement, found under *Guidelines on Conducting Self Audit for Community Support Providers*.** Providers are to follow the process described, complete the findings documents and the Affirmation Statement. This

documentation, including payment for any monies due to the Medicaid program as determined by the self-audit, is to be sent to:

Office of the Controller
DMA Accounts Receivable
2022 Mail Service Center
Raleigh, North Carolina 27699-2022

A copy of the findings documentation and Affirmation Statement are to be sent to:

ATTENTION: PARS/Self Audit
DMA Program Integrity
One Bank of America
421 Fayetteville Street
Raleigh, NC 27606

Program Integrity will log receipt of the documentation and the self-audit requirement will have been met.

IV. Produce proof of attendance at Access to Care training

Providers whose claims were reviewed as part of the Clinical Post Payment Review are required to attend Access to Care training. DMA Clinical Policy has furnished a list of providers who have attended this training to Program Integrity which is using this report as the single source document to identify which providers have met this requirement. If a provider has not attended this training, the DMH website should be checked for the next scheduled Access to Care training session. DMA Clinical Policy will furnish an updated list of providers who have attended training to Program Integrity as additional training sessions are held.

DMA Actions upon Receipt of All Provider Documents
DMA will verify whether the provider is a single agency or part of a corporation. If the individual provider is part of a corporation and multiple sites are included under a single TAX ID Number, **ALL** individual provider sites in the corporation that were subject to the Clinical Post Payment Review must meet **ALL** four requirements in order to be removed from payment withholds.

If the DHHS Controller's Office determines that total amounts withheld from a provider equal or exceed the recoupment amounts due to the Medicaid program, additional amounts will not be withheld. However, amounts already withheld will not be disbursed until providers have met **ALL** four requirements.

Withheld monies are not being applied automatically toward recoupment amounts due to the Medicaid program as a result of the Post Payment Review findings. If a provider agrees with the recoupment amount the provider will have the option of having withheld monies applied to the recoupment amount due to the Medicaid program. Also, if requested, the provider will be afforded the six month recoupment plan discussed above. If the provider elects the six month recoupment plan option, withheld monies will not be disbursed until the total recoupment amount has been paid to the Medicaid program.

When a provider meets all four requirements listed above, and EDS updates the payment system, the withheld monies are released and paid to the provider, assuming the provider has not elected to have the withheld monies applied against the recoupment amount owed to the Medicaid program. Providers should NOT resubmit claims where payment was withheld because EDS will disburse monies withheld when the four requirements are met.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Dempsey Benton
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